INTRODUCTION

Purpose and Goals of Task

The *Evaluation Design Study for Prevention of HIV in Women and Infants* was initiated by the Women's Health and Fertility Branch (WHFB) of the Centers for Disease Control in the fall of 1990 as 'a means of supporting the design of the program services and evaluation component of the HIV in Women and Infants Initiative. The study was assigned to the Research Triangle Institute (RTI) as a task within the Evaluation Design Studies contract administered by CDC's Office of Program Planning and Evaluation.

The task's Scope of Work defines its purpose as assisting WHFB "by assessing strengths and weaknesses of relevant existing program services and evaluation efforts; assessing barriers to successful implementation of' relevant evaluation efforts; and determining the feasibility of successfully evaluating key indicators of program performance."

Task Activities

As described in the Workplan, the task's principal information-gathering activity was a series of site visits to programs addressing prevention of HIV infection in women and infants. RTI staff visited fifteen programs in five states during October and November. Discussions at each program followed an informal outline that had been approved by the Task Order Director. Whenever possible and appropriate, the site visit included observation of actual program operations.

For each program visited, we prepared a description of its goals, program activities, participants and evaluation activities. These were supplemented, in a document submitted to WHFB on December 14, 1990 by assessments of each program's evaluability. Evaluability, as described by Wholey,* refers to the extent to which programs have:

- well-defined objectives with quantifiable outcome indicators for which data can reasonably be obtained;
- plausible links between program activities and intended effects; and
- well-defined uses for evaluation results.

These evaluability analyses described any inherent threats to the program's ability to achieve its stated goals, and opportunities and constraints that

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* Wholey, JS. *Evaluation: Promise and Performance.* Washington, DC: The Urban Institute, 1979.

could potentially influence the kinds of evaluations that could be implemented.

The remainder of this report will synthesize and analyze the information presented in the program models and evaluability analyses. It will conclude with recommendations as to how the choices made by WHFB in developing the Initiative's program services component can influence the kinds of evaluation activities to be conducted by the programs that it supports.

PROGRAMS VISITED

Sites to be visited were chosen on the basis of recommendations in response to inquiries from the Task Order Director. An attempt was made to maximize the variation among sites in terms of region, type of program activities and target population. Programs emphasizing reproductive health care and outreach to hard-to-reach populations were of particular interest. The principal program and evaluation activities for each program visited are summarized in Figure 1; individual programs are described in detail in a report and supplementary materials submitted to WHFB on December 7, 1990.

Although no two programs were exactly alike, several employed similar service delivery models. For each of these general models, we will briefly identify the programs and discuss common themes regarding objectives, populations and needs addressed, and strengths and weaknesses. We then discuss evaluation experiences in terms of the barriers and opportunities posed by each of the program models.

Peer Education

Program Model. Three of the programs visited use peer education as the major component of their service delivery model:

- Life Force uses community workers, some of whom are HIV positive, to provide prevention education to women who are at high risk for HIV infection.
- The Bronx Perinatal Project trains community members as health workers who provide outreach and educational services to women of childbearing age in their own and surrounding communities.
- CAL-PEP uses community health outreach workers to reach sex industry workers by providing prevention education, educational materials, risk reduction and ongoing emotional support.

Figure 1. Summary of Programs Visited

Program Name/ Location	Principal Program Activities	Evaluation Activities
Planned Parenthood Baltimore, MD	Group sessions for female and male adolescents emphasizing clarification of values and life goals, information about prevention of STDs and unplanned pregnancy.	Pretest/posttest measures of knowledge, attitudes, risk behaviors and self-efficacy for prevention activities.
Cook County Hospital Women and Children with AIDS Project Chicago, IL	Comprehensive case-managed services for women and children with HIV infection and AIDS, including clinic, support group, social, legal and family services; education to high-risk women; peer education.	Process measures for all health education activities; cost of case-managed services; patient satisfaction; services needed vs. received.
Pediatric AIDS Program New Orleans, LA	Comprehensive case-managed care for seropositive infants and their families; health education, counseling and referrals.	Volume, cost and compliance for case-managed services; process measures and some pre/post measures for health education.
San Francisco AIDS Foundation San Francisco, CA	Supportive services for people with AIDS and ARC, including counseling, support groups, benefits counseling and referrals.	Descriptive client statistics and counts of the number of unduplicated client visits.
BA-PAC (Bay Area Perinatal AIDS Consortium) San Francisco, CA	Study of the natural history of HIV infection in seropositive infants; provides medical care to pregnant women and young children, referral to related services.	Developing pretest/posttest instruments for use with planned health education program.
FACET (Family Addiction Research and Treatment) San Francisco, CA	Services to drug-addicted pregnant women and their children, including drug treatment, prenatal care, developmental day care, education and counseling.	Collecting data for evaluation but analyses not yet planned; client statistics, and monitoring program development.

PHREDA (Perinetal HIV Reduction and Education Demonstration Activity) San Francisco, CA	Randomized trial comparing delivery of contraceptive services to high-risk women in traditional and non-traditional sites, using indigenous health workers for outreach and recruitment.	Outreach worker re-interviews clients every six months to update knowledge, attitudes and behaviors related to contraception and risk behaviors.
CAL-PEP (California Prostitutes Education Program) San Francisco, CA	Community health outreach workers provide information about risk reduction and support for behavior change to sex industry workers.	Individual risk data collected during educational presentations; pretest/posttest "safe sex quiz"; individual behavior change commitments.
The Center Oakland, CA	Multi-service center for people with HIV infection, provides day center, counseling, hot lunch and food bank.	No formal evaluations.
Orange County Center for Health Anaheim, CA	Outreach and education for adults at risk of HIV infection through community presentations and clinical service contacts.	Pretest/posttest and individual commitments for behavior change; informal assessment of group response to presentations.
Joint Efforts San Pedro, CA	Outreach and education to partners of persons at high risk of HIV infection in the Hispanic and Filipino communities.	Needs assessment survey planned, process measures, pretest/posttest planned.
The Door New York, NY	Multiservice center for youth including education, health and recreational services.	Several ongoing evaluation projects, unable to identify evaluation related to HIV education.
Life Force New York, NY	Peer education program in which women affected by HIV provide outreach and education to women at risk.	Pretest/posttest for peer educators, process measures for outreach, informal assessment of impact for educational presentations.
Bronx Perinatat Consortium New York, NY	Peer educators work with minority women to increase their sense of vulnerability to HIV infection.	Process measures, individual problem-oriented records where ongoing contact is established.

Two other programs discussed elsewhere (Planned Parenthood of Maryland and Cook County Hospital) have added peer education training as a means of capitalizing on the experience and resources of their program participants. Of the three programs discussed here, the Bronx Perinatal Project is the only one operated in conjunction with a health facility.

The goals and objectives of these programs focus on disseminating information aimed at prevention, reducing risky behavior, and making referrals for needed services. All use the peer education model to reach otherwise hard-to-reach women at high risk in specifically identified communities. Programs using this approach hope to increase their effectiveness by using community members who are known, trusted and credible to deliver sensitive messages in a manner that is responsive to the audience's learning needs and culture. The model encounters difficulty, however, when community workers attempt to enter communities with which they are not familiar, where they may encounter less openness and even resistance. Programs may need to look beyond simple racial, ethnic and economic similarities and work toward development of peer educators who are indigenous to the specific community that they serve.

Peer education is a particularly appropriate mechanism for imparting new information to groups that may have limited prior contact with health care agencies. It is also a powerful method of empowering lay individuals to be involved in making a difference in their own communities while enhancing their own capabilities and self esteem. Development of peer educators requires structured training, with extensive investment of teaching personnel and curricula. At Life Force, the training program initially proposed for two weeks took two months. To continue skill development and maintain enthusiasm, two of these programs have also instituted ongoing support groups for the peer educators.

Evaluability. All of the programs report successes in the implementation of their programs, in that information presented to communities is usually well received and attendance at sessions reflects community awareness. There are, however, limitations to the evaluability of peer education programs, particularly in the availability of data related to indicators of intended outcomes. Time limitations and the informality of the interaction -- which is presumed to be critical to its effectiveness -- make even pretest/posttest measures of changes in knowledge difficult to incorporate into the intervention. Educators instead rely on process measures to monitor the degree of contact with the target community, and on subjective assessments of partici-

pant reactions through audience questions and feedback following the sessions. Subjective assessments provide useful, if informal measures of the impact of presentations, but even these may be constrained by limited time and the large group format. Another difficulty is that one-time presentations do not allow measurement of any sustained changes in attitude or behaviors, although these are less closely related to program activities than are changes in knowledge.

CAL-PEP is an exception to many of these issues, in that it targets a specifically-defined community and structures its interactions to developing ongoing relations with as many of its members as possible. For example, use of a recreational vehicle for repeated visits to different neighborhoods creates a highly visible presence through which CAL-PEP workers become known to the sex workers, and the van's use for rest breaks facilitates informal educational interactions. Evaluation is incorporated into educational contacts through such means as a second outreach worker who collects data during presentations, and presentation of the pretest/posttest instrument as a contest with a cash prize.

If innovations such as these cannot be structured into their interventions, peer education programs may need to rely upon other forms of assessment, such as periodic indepth interviews with community leaders to identify information needs and underserved groups within the community. To the extent that peer educators build relationships with community members in which ongoing support and referrals to services are offered, there is also the possibility of assessing changes over time, although not with large numbers of persons. The most feasible and useful improvement in evaluation practice, however, may be the incorporation of a limited assessment of audience comprehension of key information points into presentations whenever possible.

Case-Managed Care

Program Model. We visited four programs that provided comprehensive, case-managed medical and social services to women. Although each provides similar services, they differ somewhat in their primary emphasis and target population:

- Cook County Hospital's Women and Children with AIDS Program provides medical and support services to women with HIV infection and AIDS and their children;
- New Orleans' Pediatric AIDS Program provides medical and support services to seropositive children and their families;

- San Francisco's BA-PAC provides comprehensive medical care and referrals to related services for pregnant seropositive women and their children up to age five;
- San Francisco's FACET provides drug treatment, medical care, social service referrals and developmental day care to drug-using pregnant women and their children.

Each of these programs improves women's access to services in at least three important ways. First, they provide high-quality medical services to women who, because of their socioeconomic circumstances, would have difficulty obtaining them otherwise. Second, they bring needed support services (such as legal representation, drug treatment, and day care) together, either physically or through a referral system. These linkages increase access by reducing barriers of poor transportation, language and unfamiliarity. Finally, case managers provide guidance through the system by identifying needed services and assisting women with their access and use.

Staff at each site emphasized the need to structure programs in such a way as to increase utilization of needed services by reducing barriers to access. Reduced mobility due to inadequate transportation and child care responsibilities, complicated by poor health and overcrowded facilities, frequently discourage women from using services. Bringing representatives of other agencies to the program, providing services to both women and children in the same part of the hospital and on the same day, and providing child care while mothers receive medical treatment are all critical to encouraging utilization. In many instances, one service that is particularly desired (such as medical care for a child) functions as the "hook" by which a women is drawn into the program and then persuaded to make use of other services (such as medical care for herself) that might otherwise be neglected. The task of delivering needed services is made more formidable by the fact that clients of these programs are typically severely underserved, independent of their HIV status. Thus, the medical care provided includes not only services for HIV-related conditions but basic primary care as well.

Each of these projects serves women and infants who are already HIV-infected, with the exception of FACET, which estimates that only eight percent of the women served are seropositive although all are at risk because of their involvement with drug use. In terms of prevention goals, therefore, only FACET provides primary prevention services by reducing risk behavior among uninfected women. All programs limit perinatal HIV infection to the extent

that seropositive women may, as a result of education and counseling, decide to avoid future pregnancies or limit future infective exposures by reducing risky sex and drug use. Finally, these programs provide secondary and tertiary prevention through early diagnosis and treatment of HIV-related conditions, minimizing the extent of disease-related disability and improving the quality of life for infected women and children.

Evaluability. Because of the comprehensiveness of the services offered, and because they maintain contact with participants over a relatively long period of time, case-managed care programs have the opportunity to do more extensive evaluations than any of the other program models discussed here. Individual records contain a wealth of data describing, for example, the participant's medical, financial, family structure, and housing status. Particularly if there is access to a comparable group of patients who are not receiving case management, the areas of useful analyses that could be performed with this information are potentially enormous, including such questions as:

- Does case-managed care maintain or improve the quality of life, in terms of financial support, housing and access to social services for families affected by HIV?
- Does case-managed care improve compliance with recommended services for adult or pediatric patients?
- Is the cost of care, including inpatient hospitalization, greater or less for patients under case management than for those who are not?
- Do women in case-managed care setting make different decisions regarding contraception than others?

While additional research questions could easily be identified, questions such as the above would have an immediate value in assessing the effectiveness of such programs in improving access to services for women and children affected by HIV. However, any one of these would also represent a substantial analytic undertaking that may well be beyond the resources available to the program in terms of staff time and expertise. The potential complexity of the evaluations that could be performed is in sharp contrast with the fact that evaluation activities at-the programs visited have generally emphasized simple evaluation approaches such as process measures, and devoted at least as much evaluation effort to their health education components as to the larger and more complex case management programs. It is worth noting that, of the programs visited, evaluation activities were most extensive at the one site

that had arranged within its funding for an evaluation subcontract with another organization.

Case-managed care programs are unique among the models discussed here in the amount of evaluation data that are potentially available to staff. As with all of the models, evaluability could be considerably enhanced by development of explicit statements of program objectives and identification of a limited set of evaluation questions of interest to program staff.

Multi-Service Programs

Program Model. Three of the programs visited provide a wide range of services, not medically-based, that are utilized by clients on an as-desired basis:

- The San Francisco AIDS Foundation offers counseling, referrals, support groups and benefits counseling to people with AIDS.
- In Oakland, The Center provides pastoral counseling, a day center, hot lunches, support groups, a food bank and volunteer visitors to people with AIDS.
- In New York City, The Door provides educational, recreational, and medical services to young people, as well as social service referrals, counseling and legal advice.

Of the three programs, only the San Francisco AIDS Foundation includes a component specifically targeting women, although it differs from the general program only in its attempt to address specific issues and referral sources of interest to women in addition to the services offered to male clients. The Door is the only program that offers medical services and also the only one of the three that is not focused specifically on AIDS, although risk reduction counseling is an important part of its medical and social services. It is thus the only program visited where AIDS-related services were based on primary prevention. The other two programs serve people who are HIV-positive and who have generally been diagnosed with AIDS.

Each of these programs takes a broad view of its service mission, with components added to the program in response to needs identified by clients or staff. This comprehensiveness is characteristic of the programs' efforts to respond to client needs as fully as possible; as with the case-managed medical programs described above, clients are often drawn to a specific service, then encouraged to make use of others as appropriate. For women, survival-oriented services often provide the initial point of contact, such as benefits counsel-

ing or (at the Center) laundry facilities. Staff noted that women are generally slow to make use of such non-urgent services as psychological counseling and supportive health care.

At the same time, their comprehensiveness makes these programs difficult to fund and administer. Because many funding sources are categorical, supporting only education, health care or housing, for example, programs that cannot find block funding from local government or private sources spend enormous amounts of time securing funds and reporting on their use. The diversity of services offered also requires the involvement of a large number of individual staff members, often on a part time basis, in order to ensure that all required resources are represented.

Evaluability. The diversity and open structure of these programs preclude many of the systematic evaluation activities that might be initiated under other program models. In fact, of all the programs visited, these placed the least emphasis on attempting to measure their activities and impact. This is perhaps understandable in terms of the general nature of program missions, which (insofar as they are stated at all) address broad themes of support and improved quality of life. Given such globally-stated goals, it will be difficult (if not impossible) to document achievement or to link improvements to program participation. At the same time, staff in these programs did not appear to place a high priority on documenting program operations and effects; this may again be related to their programs' broadly-conceptualized goals. It may also reflect in part the fact that none of these three programs is funded by any Federal agencies, so that there is less external pressure to evaluate.

The amount of evaluation that these programs could readily perform is also limited by the amount of data that is routinely collected within program operations. Although each of these programs maintains individual client records, these are not generally used to record service use on an ongoing basis, but more likely to be updated periodically to record the perceived needs and the kinds of services used during the intervening period. If program staff were interested in conducting more evaluations, routine data collection procedures could be modified to allow assessment of which parts of the program were most heavily utilized by different groups (although staff may feel able to assess this informally), and what outstanding needs the program is not addressing. Additional data on client satisfaction with various services could also be of direct relevance to ongoing program planning and

improvement. As a first step in increasing evaluation activity, staff members in these programs could identify evaluation questions that are of sufficient interest that they are willing to implement data collection activities and analysis.

Professionally-Led Education

Program Model. Four of the programs visited used the presentation of education by professionals, generally in clinical settings, as their methodology. The format was less structured than some of the others and its implementation differed at each site. Often education programs were mixed with other programs and services.

- San Francisco's PHREDA provides risk reduction and contraceptive education in combination with family planning services delivered in traditional and non-traditional settings. Community health workers provide outreach and followup to women at high risk of HIV infection.
- In southern California, the Orange County Center for Health provides outreach and prevention education to persons at high risk of HIV infection and their families. Services provided to the predominantly low-income and ethnic minority community are integrated with routine medical/health care as well as extended to other community based settings.
- Southern California's Joint Efforts program provides outreach, education, counseling, and referrals to partners of individuals at high risk of HIV infection in the Hispanic and Filipino communities. Outreach workers use a variety of settings to establish contact with the target population.
- Planned Parenthood of Maryland uses structured group and individual sessions to encourage in responsible sexual decision-making in adolescent females and males at high risk for HIV infection.

The focus of the educational offerings across programs was primarily primary and secondary prevention targeted at reducing at risk behaviors, changing attitudes, and increasing service utilization. Educational sessions were provided on an ongoing basis to individuals receiving clinical services, to individuals or groups on a one-time basis, and (in the case of Planned Parenthood) as part of an ongoing group format.

Although programs provided by these agencies were directed toward different populations (e.g. adolescents, adult men and women, partners of IV drug users, various ethnic groups), the provision of education along with

other needed services is the common thread throughout. In each agency, education was to some degree integrated into medical, family planning, or drug treatment services.

Education delivered by professional personnel, as opposed to peer educators, may carry increased credibility due to the connection with the sponsoring service agency and the educator's professional identification. A professional educator might also be more persuasive in encouraging the use of other services. These same factors may also emphasize the social distance between educator and client, reducing receptivity on the part of clients. This potential for distance creates a greater need for educators to anticipate client needs, to plan programs and services to meet these needs, and to create incentives for program attendance. Use of community workers for initial outreach may help to form a bridge between the client and professional educators.

Evaluability. Since this group encompasses a diverse set of programs, it is not surprising that the extent of evaluations performed varies as well. The two programs that rely on street outreach and group presentations encounter limits to evaluation similar to those experienced by peer education programs. For these programs, time constraints and limited opportunity for followup with participants after the educational programs end pose potential barriers to longitudinal evaluation. When clients are also seen for medical or family planning services, this ongoing contact provides more opportunities for followup assessments, as are performed by PHREDA. For these programs, however, the integration of education into clinical services may make it more difficult to define the educational intervention that is delivered (since the time spent and style of presentation may vary from one client to another), thus making attribution of outcomes problematic. An ongoing group format, such as that used by the Planned Parenthood program, provides access to participants over the length of the program (in this case, six months), but even that is less than satisfactory in assessing lasting behavior change. For all of these programs, increased or continued use of clinical services may be a goal of the outreach component; measurement of this effect should be fairly straightforward.

CONCLUSIONS AND RECOMMENDATIONS

Programs

Clearly, the programs visited met the goal of diversity in their target populations and service offerings. Programs visited were almost equally

divided between primary prevention via peer or professionally-led education, and secondary/tertiary prevention in the form of services to infected or diagnosed women and children. In general, primary prevention programs serve a more diverse population. From one perspective, all women (especially adolescents) are at potential risk; at best, there are no clear methods for defining precisely which women are at risk. Secondary and tertiary prevention programs generally offer more extensive services to infected women but are limited in the extent to which new infection can be prevented.

Program staff in each of the cities visited noted the scarcity of services targeting the specific needs of women at risk, especially in areas where women are only recently being identified as a population at risk. Another common theme was the lack of awareness of risk to women in programs targeting men; one individual describing a risk reduction program for male drug users complained that "they forget that cocaine users have sexual partners and families, too."

A common theme across the programs visited was the need to overcome barriers that inhibit utilization among those women most in need of services, described by one service provider as "poor, isolated and disenfranchised." Typically, the women most at risk are the most difficult to reach with education and services. The extent of their unmet needs is frequently matched or overshadowed by barriers such as poor transportation, responsibilities for young children, hesitation about self-identification and group participation, and a cultural orientation to de-emphasize their personal needs. Barriers to access are likely to be particularly handicapping for educational programs that do not serve more urgent needs, such as medical care for acute illness. Programmatic responses to these barriers include the use of indigenous outreach workers or educators and the centralization of services, with survival-oriented offerings (such as medical care for infants or benefits counseling) used to encourage women to participate in preventive services.

Evaluability

In terms of the three dimensions of evaluability described on the first page of this report, one striking (although not unusual) finding was how few programs had explicitly defined their intended outcomes. Although it is doubtful that this deficit is the major barrier to evaluation, systematic evaluation activities require clearly-stated goals and objectives, except for open-ended, goal-free evaluation approaches. Initiation of more extensive evaluation activities might force programs to develop explicit statements of

intended outcomes. In addition, many programs described their intended effects in terms of outcomes which, although measurable, would require data that could not be readily obtained by the program.

None of the programs visited seemed to violate the second condition of evaluability, plausible links between program activities and intended effects (insofar as intended outcomes were stated or could be surmised). In terms of the third condition, clearly-defined uses for evaluation information, many of the program staff interviewed could not identify specific applications for which evaluation data were desired. While all expressed interest in knowing whether their programs were effective, few could articulate specific questions about the impact of a specific aspect of the program or possible program modifications that might be guided by evaluation results. Identification of questions that are relevant to the program staff's interests might provide an effective incentive to initiation and use of evaluation.

Principal barriers to conduct of more extensive evaluation include lack of evaluation expertise among program staff, inadequate funds for evaluation and programmatic limitations to the type of evaluation that can be done. Many of the programs visited seemed to find it difficult to develop appropriate approaches to answering their evaluation questions. In some cases, it seemed that evaluation plans were based on familiar approaches (i.e., pretest/posttest measures of change in knowledge) rather than the staff's priority information needs. Similarly, many programs relied almost exclusively on process measures as their evaluation program, although it is also true that these data were not collected in all instances in which they might be useful. It is worth noting that those programs with the most extensive and sophisticated evaluation efforts were either consortia in which one partner was primarily responsible for evaluation or had subcontracted evaluation responsibilities to another group. Where funds were not sufficient to allow this sort of specialization, evaluation generally was less systematic and comprehensive.

As noted in the program model descriptions, educational interventions, in particular, were generally able to assess only changes in knowledge. Where educational contacts were informal or were integrated into other services, even pretest/posttest measurement of increased knowledge was difficult. The principal programmatic limitation to evaluation of longterm changes in attitudes and behaviors (the desired outcome of most education and risk-reduction efforts, although whether information alone can stimulate behavior

change is still a matter of some debate) was limited access to participants for repeated measurements. Ongoing contact with program participants appears to be necessary in order for programs to achieve or measure changes in attitudes and behavior. This was most often possible in programs providing medical and social services to HIV-infected women and infants. These programs also offered the possibility of evaluating such issues of service utilization under different delivery programs and the impact of case management, although these opportunities were frequently not pursued.

Recommendations

Broadly speaking, our site visits were divided among programs responding to two types of service needs: education of women at high risk of HIV infection, and comprehensive services to HIV-infected women and children. Although each is critically important, the former strategy may be seen as more consistent with an emphasis on primary prevention and with the delivery systems of WHFB's traditional partners.

Among programs providing education to women at risk, evaluation opportunities were limited by the lack of ongoing contact with participants. Two program approaches offered innovative strategies in which ongoing contact enhanced both the educational intervention and the feasibility of evaluation. The first was Planned Parenthood's group using education and empowerment to support responsible sexual decision-making by adolescents. Although the experience of other programs suggests that it is unlikely that adult women would participate in such an ongoing group, the program appears to offer a potentially effective influence on adolescents who are in the process of forming values and decisions regarding sexual behavior. Although first-year evaluation results were less conclusive than had been hoped for, the face validity of the approach and its opportunities for evaluation make it attractive.

The second example of innovative design in both program and evaluation is PHREDA's use of non-traditional settings to deliver contraceptive services and risk-reduction counseling to high-risk women. This approach addresses critical barriers to utilization among women at risk in two ways: through use of indigenous workers for outreach and followup, and through the bundling of contraceptive and educational services with survival-oriented services such as food banks. PHREDA's own evaluation, for which initial data are not yet available, will focus on comparing contraceptive service use and HIV-related knowledge, attitude and behaviors in traditional and non-traditional services

settings. Information from many of the sites visited suggests that non-traditional settings should be far more effective in serving high-risk women. In addition, the likelihood of ongoing need for survival services increases the probability that women will be available over time for can be re-interviews.

In terms of WHFB's planning for evaluation activities within the HIV in Women and Infants Initiative, two important considerations are the specification of WHFB's own evaluation priorities, and the organization of evaluation activities within the Initiative. First, in considering the extent and complexity of evaluations to be performed by the program services component, WHFB staff will need to define the questions that they will want answered by evaluation. For example, would descriptions of the number and type of services provided and participants served be adequate, or is it important to measure the impact of the program on participants? Even within these questions different levels of inquiry are possible. The target group may be defined and described in terms of demographic characteristics or behavioral risks; program impact could be measured in comparison to entry status or to predefined standards, or in comparison to another intervention or no intervention.

The extent to which information will be used to modify the program over time and to justify its continued funding may be an important part of these considerations, as well as the amount of Initiative funding that WHFB is willing to allocate to evaluation. There are no simple guidelines as to what proportion of program funding should be devoted to evaluation. The Public Health Service has used a one percent set-aside as a source of evaluation funding, but it is not assumed that this constitutes adequate resources for measurement of program effects. A more widely-accepted rule of thumb is that five to ten percent of program funds should be used for evaluation; the higher proportion would be appropriate in instances where the interventions being tested are relatively new and there is no consensus as to what is likely to be effective.

Another important consideration is how evaluations will be organized: who will be responsible for conducting the evaluation, and whether strategies will be developed centrally or by individual grantees. As noted earlier in the report, few of the programs visited appeared to have adequate expertise in program evaluations, and those that had assigned program evaluation to a subcontractor or consultant were more likely to have well-developed evaluations in place. An additional advantage is that creation of a contractual

arrangement makes it more likely that funds will be in fact be used for evaluation as planned. One organizational option would be for WHFB to select a single contractor to design and monitor evaluations at all sites, and to analyze evaluation data. This arrangement would provide a source of expertise to all programs, would enhance the impartiality and credibility of evaluation findings, and could provide a means of increasing comparability of evaluation methods and data across program sites. Such comparability could increase the credibility and statistical power of evaluation findings, as well as reducing costs for development of data collection instruments and analyses.